

Akeem Henderson, et al. vs Willis-Knighton Medical Center  
Richard M. Sobel, M.D.

November

tabbles

EXHIBIT

4

1 UNITED STATES DISTRICT COURT  
2 FOR THE WESTERN DISTRICT OF LOUISIANA  
3 SHREVEPORT DIVISION

4 AKEEM HENDERSON, et al.,

5 Plaintiffs,

CASE NUMBER

6 vs.

5:19-CV-00163

7 WILLIS-KNIGHTON MEDICAL CENTER  
8 d/b/a Willis-Knighton South  
Hospital,

9 Defendant.

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11  
12 DEPOSITION OF  
13 RICHARD M. SOBEL, M.D.

14  
15 November 26, 2019

16 10:02 a.m.

17  
18  
19  
20 105 Tivoli Gardens Road  
21 Peachtree City, Georgia 30269  
22 Thomas R. Brezina, CRR, RMR, CCR-B-2035  
23  
24  
25

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1 up. "If the oxygen saturation is maintained at  
2 95 percent or greater, it may be discontinued."

3 Is that appropriate?

4 A Generally speaking it's appropriate.  
5 It doesn't mean that you're going to want to  
6 discontinue it in all cases, but yeah. If it's not  
7 maintained at 95 percent, I think it's very clear  
8 that you should not be discontinuing it.

9 Q Does the child with a compromised  
10 respiratory system such as this patient, tend to  
11 have a lower O2 saturation rate, perhaps, than a  
12 healthier child?

13 A It's possible.

14 Q Would you defer to the expertise of a  
15 pediatric physician, perhaps, on that?

16 A No.

17 Q Your next paragraph it looks like  
18 you're getting into the facts of the case, on  
19 February 10th at 0154. See where we're getting  
20 there? Before we get to that, what is a space lab  
21 monitor? It's not in your report. Do any of the  
22 ERs where you've worked in the past, have a space  
23 lab monitor?

24 A I've seen them, yes.

25 Q And have you used those? I mean, is

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1           Q           And how do you define respiratory  
2    distress in this situation?

3           A           Well, I think I defined it pretty well.  
4    This is a classic description of it. In the next  
5    paragraph on page 6, "Ailiyah presented in a, quote,  
6    tripod, unquote, position with frank respiratory  
7    distress. Per Susan Rainer, RN, at 2:05 a.m. she  
8    was, quote, distressed; quote, uncomfortable; and,  
9    quote, anxious."

10                   And then I went on to explain what --  
11   the clinical implications of the tripod position.  
12   It's the physical stance which may be the hallmark  
13   of children experiencing respiratory distress. It  
14   would be very typical, so this would be an obvious  
15   case of respiratory distress.

16           Q           And the tripod position was noted by  
17   the nurse, is that correct, in her 2:05 note?

18           A           I believe it was at 2:05.

19           Q           And we might go ahead and attach a copy  
20   of the record.

21                   MR. ROBISON: Sedric, are you there?

22                   MR. SEDRIC BANKS: Yes, please.

23                   MR. PUGH: These are the ones that I  
24                   e-mailed to you.

25   BY MR. ROBISON:

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1           Q           We're still at the first paragraph when  
2     the patient first presented to the emergency room on  
3     February 10. It was 2:05 a.m., correct, and the  
4     patient was sitting in tripod position. Can you  
5     just explain for us what that is?

6           A           Sure. I can see arrival time is 1:54.  
7     The first citation of the tripod position is at  
8     2:05. Then there is another citation of it by the  
9     nurse at 2:11, and it looks like there is another  
10    citation at 2:22, which is associated with a  
11    correction and a crossout.

12                    The tripod position is essentially a  
13    three-point position where a person is supporting  
14    their thorax with their hands, so typically they  
15    would have their palms on a gurney. Could even be  
16    fists closed on the gurney. Those would be the two  
17    points of the triangle, and the third point would be  
18    the -- the pelvis or the patient's sitting on the  
19    gurney.

20                    So when they're in the tripod position,  
21    they're leaning forward to help the lungs become  
22    more freely mobile. Essentially take the -- the  
23    weight of the body off the lungs and enable  
24    accessory muscles to be a little bit more effective  
25    in moving the thorax.

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1                   The whole reason for that is  
2    bronchospasm and decreased air exchange, so this is  
3    the -- the signature of respiratory distress and the  
4    potential for respiratory failure, which is what she  
5    experienced when she died.

6           Q           And that would be comparable to a  
7    person or an adult leaning forward? In other words,  
8    with your hands on your knees if you are out of  
9    breath? The same?

10          A           Could be. It could be. If you are in  
11   a chair, you could be tripodding in that manner,  
12   yes.

13          Q           You're referencing the 2:05 note from  
14   the nurse that indicated the patient currently  
15   sitting in tripod position, and I'm showing that is  
16   on page 769. Wait. I'm sorry. Seven --

17          A           Sixty-six, I think. 766 is what I see.

18          Q           That's on the nurse's notes; correct?

19          A           Yes.

20          Q           And it indicates there that the patient  
21   has strep throat and -- right?

22          A           Well, actually the records that you  
23   have submitted to me are a little bit different than  
24   the records that I have received. I must say I  
25   think I've received maybe three -- at least three

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1 should be hooked up to the monitor with continuous  
2 pulse oximetry. Should have continuous  
3 plethysmography, respiratory rate, the heart rate.  
4 Should be on supplemental O2.

5 This is a child that's got to be wired  
6 for sound, and IV is -- needs to be started.  
7 Intravenous steroids, magnesium, continuous  
8 bronchodilator therapy. The die is cast when this  
9 child arrives at the hospital. This is a child that  
10 needs to be admitted.

11 Q Under -- since we're looking at that,  
12 on the nurse's notes we're looking at vital  
13 statistics at 0323, what do those say? The pulse ox  
14 goes to 99 percent, correct, and 99 percent is good?

15 A No. This is the result, more likely  
16 than not, within reasonable medical certainty, if  
17 you would like to use the term, of the patient  
18 getting a neb treatment --

19 Q So she --

20 A -- with oxygen.

21 Q So the patient was treated and got  
22 better?

23 A So -- no. So this is the pulse  
24 oximetry that is measured on high-flow O2.

25 Q Where is that documented?

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1 A So it's not a room air pulse oximetry.

2 Q And where is that part documented, that  
3 she is on oxygen at that point?

4 A Well, look at time of the nebulizer  
5 treatment. So there is an albuterol nebulizer  
6 treatment that is begun at 3:16. That is given with  
7 high-flow O2.

8 Q Is that appropriate? Is that an  
9 appropriate treatment?

10 A Yes. Yes, it's appropriate. So if you  
11 note in the previous records, they document pulse  
12 oximetry on room air, especially when she went home.  
13 There was a pulse oximetry documented on room air.  
14 That's what you need. In this particular case the  
15 first pulse oximetry was on room air, so that is  
16 prior to the neb. The neb is given with oxygen, and  
17 the second pulse oximetry, there is no documentation  
18 of being on room air. That it's taken simultaneous  
19 with an albuterol treatment, which is given with  
20 oxygen, so --

21 Q Before we get there, since we're  
22 looking at administered medication, which would be  
23 in the nurse's notes continued -- I think you're  
24 looking at that now?

25 A On 767.

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1 To get to a safe discharge after this presentation?

2 I would have to say it's impossible.

3 Q Do you always repeat in your dictation,  
4 what is in the nurse's dictation?

5 A You have to address it.

6 Q But do you --

7 A I don't always repeat it, but if the  
8 nurse says something that is not accurate, then I  
9 address it and say why it isn't accurate and why --  
10 how it's different from what I found.

11 Q How long does a pediatric patient  
12 typically remain in a tripod position after being  
13 treated?

14 A Well, there is no way to assign a  
15 number to that. I mean, they may proceed from the  
16 tripod position to intubation and sedation, so that  
17 all could happen over the course of five minutes --  
18 the tripodding is over because the patient is on a  
19 ventilator -- or it may persist for, who knows;  
20 quite a while.

21 Your goal is to improve the patient's  
22 condition, get them out of the tripod position  
23 clearly because it's totally nonreassuring, and it  
24 is an indication of respiratory distress.

25 Q In your opinion on page 7 you're noting

1 that it takes 20 to 30 minutes of washout time for a  
2 valid reading of O2. What does that mean?

3 A Well, that means when you increase the  
4 FIO2 or the percentage of oxygen in the air by  
5 giving supplemental oxygen, the oxygen replaces the  
6 nitrogen in the lungs, so essentially you're going  
7 to a different planet. Planet Earth is 21 percent.

8 If you put a child on 50 percent, it's  
9 like you're breathing an oxygen concentration of  
10 50 percent in the atmosphere, so that is going to  
11 artificially increase your oxygenation, and that is  
12 reflected in the pulse oximetry. That is why you  
13 have a pulse oximetry of 99 percent in this case:  
14 Because you've supplied supplemental oxygen. It has  
15 to wash out over time, so you start breathing the  
16 regular oxygen-level air. It's 21 percent. You got  
17 to breathe that for a while.

18 And the 50 percent oxygen atmosphere  
19 that you have delivered to the patient, the term is  
20 washout. It washes out, and the nitrogen comes back  
21 in and replaces the oxygen. After that happens and  
22 the supplemental oxygen is washed out, then you can  
23 repeat the pulse oximetry and see if it's stable,  
24 and that is what the policy or the protocol is  
25 reflecting: That you need some time for the washout

1 of oxygen, the supplemental oxygen to wash out.  
2 Q Does it always -- are those times  
3 preset for a child that is four years old with  
4 compromised lungs from birth? The 20 to 30-minute  
5 time?

6 A Just gave a rule of thumb. You can  
7 tell how fast it's deteriorating. You could maybe  
8 make the call in just a few minutes if it starts  
9 precipitously dropping. So what you don't have is  
10 verification of a -- of a room air oxygen that is  
11 greater than 95 percent. So there is no way you can  
12 determine that this child is not going to materially  
13 deteriorate. Tachycardic, breathing too fast, and  
14 you don't have a properly obtained pulse oximetry,  
15 and you don't have anybody that is reporting a lung  
16 exam.

17 Q Does albuterol have the effect of  
18 increasing a patient's heart rate?

19 A It can.

20 Q It can, or it does? That is one of the  
21 listed --

22 A It can. It can. It can actually go  
23 down, so it depends. If you are effective in  
24 treating the bronchospasm and the child is out of  
25 the tripod position and not using any accessory